DENTAL CARE

Health Choice

The WSRC TEAM

Effective 1/1/98

INTRODUCTION

The dental care benefits described in this Summary Plan Description are sponsored by Westinghouse Savannah River Company and Bechtel Savannah River, Incorporated (WSRC/BSRI), and administered by Westinghouse Savannah River Company (WSRC). Persons eligible to participate in the WSRC/BSRI Health Choice Dental Plan include those as described herein who are connected by employment with the WSRC Team. "The WSRC Team" pertains to Westinghouse Savannah River Company (WSRC), Bechtel Savannah River, Incorporated (BSRI), Babcock and Wilcox Savannah River Company (B&W) and British Nuclear Fuels, Limited, Savannah River Corporation (BNFL).

The WSRC/BSRI Health Choice Dental Plan is a self-insured multiple employer plan which uses funds from the U.S. government and contributions from plan participants to pay the cost of claims and administrative expenses. Cost-sharing of dental benefits places the WSRC Team into a more competitive position with large employer business practices and enhances its ability to attract important missions at the Savannah River Site.

You have two dental plan options available under Health Choice — Prime Choice and Standard Choice. You also have the option of electing no dental coverage.

Prime Choice and Standard Choice cover many dental services and supplies. Both options provide benefits for preventive care at 100% of the reasonable and customary (R&C) amount. Prime Choice and Standard Choice both cover restorative services, but at different levels. Prime Choice also covers orthodontia treatment. It is important to know the differences in coverage and how much is paid by the two options for covered services.

Neither the Prime Choice nor Standard Choice Dental option involves a network of preferred dental providers, so the level of dental benefits will be the same from dentist to dentist under the option you choose.

This book provides the details of your Health Choice Dental options. Read it carefully and refer to it whenever you have a question about your dental benefits. However, if you find you need additional assistance, call the Blue Cross Blue Shield of South Carolina Customer Service Line at 1-800-325-6596.

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Participating in Dental

Eligibility

If you are a full-service employee of the WSRC Team, then you are eligible for dental coverage after you have completed one year of continuous employment. **If you are not yet eligible at the time of the annual enrollment, YOU MUST STILL ENROLL for the dental option of your choice.** Coverage will take effect on the first day of the month in which you meet the service requirement.

Coverage is effective for full-service employees after you have completed one year of continuous employment, provided you elect dental coverage at the annual enrollment.

Retirees of the WSRC Team (after April 1, 1989) with at least 15 years of credited service, and eligible survivors, are also eligible for participation in dental coverage.

WSRC Team employees with less than 15 years of credited service who have been approved for Total and Permanent Disability benefits are not provided dental coverage; however, continuation of dental coverage is available under provisions of COBRA. See "Coverage Continuation in Special Situations" of this book and COBRA continuation coverage in the General Information book.

If you and your spouse are employees or retirees of the WSRC Team, you cannot be covered both as an employee and also as a dependent.

Retirees of DuPont Savannah River Plant (retirements prior to April 1, 1989) — and their dependents (including those dependents of DuPont/SRP retirees who normally would be eligible for WSRC/BSRI Health Choice Dental coverage due to their status as an active WSRC Team employee or a WSRC Team retiree) — who are eligible for DuPont/SRP dental coverage are not eligible to participate in the WSRC/BSRI dental options described in this book.

BSRI employees participating in union benefits are not eligible for coverage under this plan.

Enrolling for Coverage

During the Health Choice enrollment process, you will be asked to elect:

- Prime Choice, Standard Choice or no dental coverage, and
- Coverage for yourself only, you and one dependent, or you and two or more dependents.

If you fail to enroll for dental coverage during the annual enrollment process, you and your dependents will not have any WSRC/BSRI dental coverage during the next Plan Year, even if you have a Qualifying Family Status Change.

NOTE: If you and your spouse are both employees and/or retirees of the WSRC Team, you will be asked if you want to be covered as an employee or as a dependent. See page 3 for Special Rules For "Dual Couples."

If you elect to cover your dependents, you must enroll them in the same option you elect for yourself. Coverage for your eligible dependents begins at the same time as your coverage if you elect to cover them, or on the effective date of a Qualifying Family Status Change, whichever applies. You must name the dependents to be covered and provide their Social Security numbers.

Remember, you cannot change your Health Choice Dental elections during the year unless you have a "Qualifying Family Status Change" (marriage, new birth, etc.) under Internal Revenue Service rules. Notify WSRC Benefits Administration of any Family Status Change within 60 days and follow the instructions in the Overview book for requests to change elections. Qualifying Family Status Changes that are approved by Benefits Administration will be effective as of the "event" date as long as Benefits Administration is notified within 60 days.

Eligible Dependents

Your eligible dependents include your lawful spouse (in accordance with state law in your state of residence) and your "children," including your own children, legally adopted children or stepchildren who primarily reside with you, and children supported solely by you for whom you have been appointed legal guardian. Your adopted children are covered from the time they are legally placed with you. You will be required to provide proof of legal guardianship or adoption. Your "children" also include children covered by a Qualified Medical Support Order which requires the Company to provide dental coverage for the children. The Qualified Medical Support Order must be properly served on the WSRC Team employee and will need to be qualified by the Plan Administrator. Benefits Administration will need a copy of the order, and the employee will be required to complete a new Health Care Enrollment/Change Form within 60 days of the qualifying event.

In order to be eligible for coverage, your "children" must: be unmarried; be under age 20; primarily reside with you in a regular parent/child relationship (or living at school while a full-time student); and you must be able to claim them as dependents on your current federal income tax return. Dental coverage may be extended up to age 25 for full-time students at accredited institutions. Blue Cross Blue Shield of South Carolina is responsible for determining student eligibility, which will be reviewed every year.

If your unmarried child is totally and permanently disabled and over the age of 20, the disability must have begun before age 20 (effective 1/1/98), and your child must remain continuously disabled beyond the age limit to be eligible for coverage. You will be requested to periodically provide proof of total and permanent disability to continue the child's eligibility under the Health Choice Dental options.

Dependents of DuPont/SRP retirees are ineligible for WSRC/BSRI Health Choice Dental coverage as noted under the "Eligibility" section on page 1.

Important information concerning surviving spouses and dependent children is noted on page 20, "If you die..."

Benefits Administration reserves the right to request, at any time, documentation as proof of any dependent's eligibility, as well as the right to remove any ineligible

dependent retroactively from coverage, including the right to seek reimbursement for claims paid on any ineligible dependent.

To add a dependent to your coverage, you must submit a "Health Care Enrollment/Change Form" to Benefits Administration (730-1B) no later than 60 days from a Qualifying Family Status Change Event.

Special Rules for "Dual Couples"

"Dual couples" are WSRC Team employees (or WSRC Team retirees) who have a spouse who also works for (or is retired from) the WSRC Team. Dual couples cannot be covered both as a dependent *and* as an employee/retiree under the dental options. In addition, no dependent child may be covered by more than one WSRC Team "parent" employee or retiree.

For example, you may elect to cover your spouse and your child, while your spouse elects "covered by spouse" and is your dependent. Alternatively, you may elect coverage for yourself and your child, while your spouse elects employee only coverage. When you make the latter choice in this example, you and your spouse may elect to be covered by different dental options. But, you and your spouse may not cover each other or both cover the same child.

Election Lock-In

If you elect to be covered by either Prime Choice or Standard Choice, you are locked-in to your election for two years. This lock-in applies to both the option you elect, and to the dependents you elect to cover (unless you have a "Qualifying Family Status Change," in which case you would be allowed to change your level of coverage — employee only, employee +1 or employee +2 or more dependents — but would not be allowed to change your dental plan option — Prime or Standard Choice). The lock-in encourages careful planning and reduces the frequency of movement into and out of the options — to help control the cost of coverage.

If you elect no coverage, you may enroll in a dental option during a future annual enrollment period.

After two years in the same option and same level of coverage, you may again elect any available option at the time of the next annual enrollment. At that time, if you **change** your coverage option, you will again be locked into your new election for yourself and for each of your eligible dependents for two years. However, if you **remain** in the same option, for at least two years, you may change options during the next enrollment period. Your personalized enrollment worksheet will indicate the options available to you, if any.

Identification Cards

If you enroll in the BlueChoice HMO medical option and also choose either the Prime or Standard Choice Dental option, you will automatically receive a "Dental Only" identification card from Blue Cross Blue Shield of South Carolina (as a supplement to your BlueChoice HealthCare Plan ID Card). However, if you enroll in one of the other available medical options (either Prime, Standard or Basic Choice Medical), your Blue Cross Blue Shield of South Carolina identification card will provide information for medical purposes and will also serve as identification which your dental provider can use to verify your eligibility for dental coverage and to assist in filing a dental claim.

When Coverage Ends

Your coverage ends when you no longer elect to be covered by one of the dental options, provided your lock-in period has ended. Your coverage also ends when you no longer meet the eligibility definitions.

Do not call Blue Cross Blue Shield with information on a Family Status Change. Instead, contact WSRC Benefits Administration.

Coverage for your dependents ends when you no longer elect to cover them (during an annual enrollment for dental coverage, provided your lock-in period has ended), they no longer meet the eligibility requirements, a "Qualifying Family Status Change" occurs (as a result, you elect to eliminate a dependent from dental coverage), or your coverage ends. You will be required to provide proof of the qualifying event within 60 days of the event; otherwise, your dependents will not have coverage under your WSRC/BSRI option, they will not be eligible for COBRA continuation coverage, and you will not be able to receive a refund of any premium contribution overpayments. In the event of a divorce, the "60-day clock" begins at the date of the final divorce decree.

Coverage for you and your dependents ends on the last day of your applicable pay period. Premium contributions are not pro-rated in accordance with your termination date. In other words, you'll have to pay the full premium contribution for the pay period in which you terminate employment. In certain situations, you and your dependents may be eligible to continue coverage. See "Coverage Continuation In Special Situations" on page 20 of this book and COBRA continuation coverage in the General Information book.

Your Cost for Coverage

You and the WSRC Team share in the cost for Health Choice Dental coverage. The amount of your premium contribution depends on the dental option you elect, and whether you elect coverage for yourself only or you and your dependents. As an active employee, your premium contributions are deducted from your pay before Social Security and federal and state income taxes are computed and withheld. If

you are a retiree or survivor, your premium contribution is deducted from your after-tax monthly pension benefit. The premium contribution is reviewed annually and may even increase during the second year of your two-year lock-in period. You will be notified of your premium contribution amount at the time of annual enrollment.

Using the Health Care Flexible Spending Account

If you are an active employee, you can use your Health Care Flexible Spending Account (FSA) in conjunction with coverage under the dental options. The Health Care FSA can be used to help pay for your coinsurance, non-covered expenses that fall within IRS guidelines, and expenses that exceed the scheduled payment amount or the reasonable and customary (R&C) amount. For more details and information on your Health Care FSA, see the Flexible Spending Accounts book.

How the Dental Options Work

Similarities and Differences of Prime and Standard Choice

The Prime Choice and Standard Choice Dental options offer identical coverage for preventive dental services only. There is no deductible for preventive services under either option. Preventive services are covered at 100% of reasonable and customary charges (R&C). However, there are major differences between the Prime and Standard options for other (non-preventive) types of dental services.

Prime Choice

Maximum Annual Benefit

The maximum benefit (the most the option will pay) in any calendar year for each person covered under the Prime Choice dental option is $2,000 for preventive and minor and major restorative services combined. However, payments made by the plan for TMJ/TMD and orthodontics do not count toward the maximum annual benefit amount.

TMJ and Other Temporomandibular Disorders (TMD)

Under Prime Choice, benefits for treatment of TMJ and other Temporomandibular Disorders (TMD) are paid at 50% of R&C up to a maximum lifetime benefit of $500 for each covered person. Temporomandibular Disorders are diseases or conditions that result in pain and dysfunction of the jaws. TMD includes jaw muscle pain, jaw joint (TMJ) conditions, and jaw growth and movement problems. The lifetime maximum is applied as long as you are covered by a WSRC/BSRI dental option, even if you elect to be covered under Standard Choice and then return to Prime Choice.

Prime Choice pays orthodontics at 50% of R&C up to a lifetime maximum of $1,500. So, for example, for R&C expenses of $2,500, Prime Choice pays $1,250...for R&C expenses of $3,000 or more, Prime Choice pays $1,500.

Orthodontics

Prime Choice covers both adult and child orthodontics. The benefit level is 50% of R&C, but not more than $1,500 for each covered person in a lifetime. The lifetime maximum is applied as long as you are covered by a WSRC/BSRI dental option, even if you elect to be covered under Standard Choice and then return to Prime Choice. To be covered, services must be incurred (actually rendered by the dentist) during the same year that you are enrolled in the Prime Choice option.

Standard Choice

While this option covers preventive services at 100% of the R&C amount, all other covered services are paid — after you've met a $25.00 individual ($50.00 family) yearly deductible — at 50% of the R&C level for covered charges. Some services (for example, TMJ and orthodontics) are not covered under Standard Choice, but are covered under Prime Choice.

The Maximum Lifetime Dental benefits used under your prior enrollment in the WSRC/BSRI dental plans count toward the Maximum Lifetime Dental Benefit for TMJ/TMD and orthodontic services.

Maximum Annual Benefit

The maximum benefit for preventive and minor and major restorative services combined under Standard Choice Dental is $1,000 for each covered person in a calendar year.

For definitions of dental terms, refer to the glossary on page 22 of this book.

Summary of the Dental Options

Option Features	Prime Choice Dental	Standard Choice Dental
Preventive	100% R&C	100% R&C
Minor restorative	80% R&C	50% R&C
Major restorative	60% R&C	50% R&C
TMJ and TMD	50% R&C $500 *lifetime maximum*	None
Orthodontics	50% R&C $1,500 *lifetime maximum* (child and adult)	None
Annual Deductible	None	$25 per person/$50 per family on covered non-preventive services
Maximum annual benefit*	$2,000 per person per year	$1,000 per person per year

* Dental option payments for preventive and minor and major restorative care have a combined dollar limit for ***each*** person. This limit — the maximum annual benefit — is available ***each*** year. However, payments for TMJ/TMD and orthodontics do not count toward the maximum annual benefit amount under the Prime Choice Dental option.

Your Share of Expenses

Regardless of which dental option you elect, there are certain expenses that you are responsible for:

- The deductible (for non-preventive services under the Standard Choice Dental option only) and coinsurance (for non-preventive services under both the Prime and Standard Dental options),
- Any expenses above the R&C level,
- Expenses not covered by the option you elect,
- Charges that exceed the maximum annual benefit,
- Charges that exceed the lifetime maximum benefit (TMJ/TMD and orthodontics), and
- Any charges for procedures that exceed or differ from widely accepted dental practice (refer to "Alternate Course Of Treatment" on page 10).

Pre-Treatment Estimate

A pre-treatment estimate — also called predetermination of benefits — is not mandatory, but it is strongly advised. Both dental options pay based on the level of treatment that Blue Cross Blue Shield of South Carolina determines is "adequate and necessary" according to widely accepted dental practices. Since dental care can be expensive, it's a good idea to find out in advance how much will be paid because benefits are limited to the course of treatment which Blue Cross Blue Shield, upon review, determines is appropriate. By getting a pre-treatment estimate, you'll know whether the services are covered under Blue Cross Blue Shield's standard dental treatment guidelines. You'll also know how much of the dentist's charges Blue Cross Blue Shield will pay. This way, you can avoid misunderstandings about your coverage.

If...

Your dentist recommends a procedure that differs from widely accepted dental practice,

Then...

You will be required to pay the difference between your dentist's bill and the amount covered by Prime Choice or Standard Choice.

When and How to Request a Pre-Treatment Estimate

If you need a course of dental treatment that may cost $200 or more, you should have your dentist complete a pre-treatment plan and submit it to Blue Cross Blue Shield of South Carolina. It's important to do this **before** your treatment begins. However, in case of an emergency, get the care you need as soon as possible. Then file your claim in the usual way.

To file a pre-treatment plan and receive an estimate of the dental option's payment, follow these steps:

- Take a Blue Cross Blue Shield of South Carolina *Dental Services Claim Form* to your dentist. These forms are available from SRS Stores (Item 26-8121.00), the electronic file server (OSR 5-342) or Blue Cross Blue Shield Customer Service.
- Check (√) the block, "Dentist's Pre-Treatment Estimate," and complete other requested information.
- Ask your dentist to complete an itemized list of services to be performed, including the cost of each service and the estimated length of treatment. Have your dentist refer to the instructions on the reverse side of the claim form to assist in completion of the pre-treatment estimate of benefits.
- Have your dentist attach any other materials that could be used to evaluate the treatment plan, such as x-rays or study models.
- Mail the claim form with the itemized list and supporting materials to Blue Cross Blue Shield of South Carolina.
- Blue Cross Blue Shield will review the pre-treatment plan and determine the amount of coverage based on the dental option you are enrolled in. If necessary, the information will be forwarded to a dental consultant for approval or determination of an alternate treatment plan.
- Blue Cross Blue Shield will notify you and your dentist, in writing, about the amount your option will pay. Remember, an alternate treatment, service, or supply may be recommended if Blue Cross Blue Shield considers the treatment program submitted by your dentist to not be necessary according to widely accepted dental practice standards.
- Your dentist should review the pre-treatment plan with you before doing the work. You should sign the pre-treatment plan to show that you understand the treatment and the dental benefits payable.
- After you have received services, your dentist should complete a claim for the actual services provided, and return it to Blue Cross Blue Shield of South Carolina.

In Case of Conflict

While you can go ahead with any course of treatment — even a more expensive one — recognize that **payment will be based on what Blue Cross Blue Shield of South Carolina considers to be "necessary, appropriate and adequate"** according to widely accepted standards of dental practice for your condition. Some examples of the types of dental treatment where reimbursement may be denied totally or in part include the unnecessary removal of impacted wisdom teeth and the installation of crowns, inlays and onlays, when a less expensive alternative treatment would be as effective. Refer to "Alternate Course Of Treatment" below for more information.

Alternate Course of Treatment

An alternate course of treatment applies when more than one dental service or supply can treat the same dental problem. Sometimes, for example, either a crown or a filling could work adequately well. All services must meet widely accepted dental practice standards.

If alternate services and supplies can be used that will equally treat your dental problems, both dental options will always pay benefits based on the less expensive alternate services or supplies. The standards developed by Blue Cross Blue Shield are based on the services and supplies that are customarily used by dentists throughout the United States, taking into account the current condition of the patient.

Covered Dental Services

Covered dental services and allowable benefits under the Prime Choice and Standard Choice Dental options are described as follows:

Preventive Care

Preventive care services are covered at 100% of R&C under both Prime Choice and Standard Choice with no deductible required.

- Routine oral examinations by a dentist — two times in a calendar year,
- Tests and laboratory examinations — when needed for diagnosis, prevention and treatment of dental problems,
- General routine cleaning and scaling of teeth, performed by a licensed Dental Hygienist or a dentist — two times in a calendar year,
- Periodontal cleaning and scaling of gums and tissues surrounding the teeth — two times in a calendar year (only following periodontal surgery or for specific dental needs such that there is a history of active periodontal scaling/cleaning as evidenced by the periodontal chart and notes),
- Emergency dental services — treatment for the relief of pain,
- Fluoride treatments — for dependent children under age 20 two times in a calendar year, regardless of the type of fluoride used,
- Application of sealants — for dependent children under age 14 once per tooth every 36 months,
- Space maintainers — for dependent children under age 20:
  - — installation of fixed or removable appliances to keep teeth from moving, and the adjustment of these appliances when required because of a change in the condition of the mouth,
- Dental x-rays:
  - — full mouth (panoramic) x-ray — once every 36 months,
  - — bite-wing x-rays — two times in a calendar year,
  - — any dental x-ray required to diagnose a specific condition.

Minor Restorative Services

- Fillings — amalgam or composite restorations,
- Oral surgery — surgical procedures in and around the mouth, including removal of cysts, malpositioned or impacted teeth partially or fully covered by tissue, when medically necessary,
- Extractions — simple or complex removal of teeth, including removal of badly decayed teeth, when medically necessary,
- General anesthesia — when medically necessary and administered in conjunction with covered dental services,
- Endodontics — treatment of diseases of the pulp, such as root canal therapy, dental root resection, pulp capping, minor pulpotomy and major apicoectomy, where indicated,
- Periodontics — treatment of diseases of the gums and tissues surrounding the teeth,
  - — Prime Choice only — splinting of teeth when necessary and as an integral part of a periodontic treatment plan,
  - — Both Options — surgical treatment of diseases of the gums and tissues surrounding the teeth,
- Denture repair:
  - — relining, rebasing, repairs and adjustments more than six months after installation or replacement, but not more than once every 36 months,
- Other repairs:
  - — repair of crowns, inlays, onlays and gold fillings
  - — repair and recementing of bridges.

Under Standard Choice, both minor and major restorative services are covered at 50% of R&C <u>after the deductible</u> has been met.

Major Restorative Services

- Prosthodontics — replacement of one or more natural teeth lost or extracted while you are covered under the options (except wisdom teeth). Refer to the Glossary of Terms for an explanation of “natural teeth.” Prosthodontic treatment includes:
  - — initial installation of fixed bridgework to replace teeth extracted while you are covered by the options,
  - — crowns, inlays, onlays, gold fillings and precision attachments and abutments for dentures and bridgework, when necessary,
  - — initial installation of removable complete or partial dentures, including adjustment during the six months following installation,

— adding teeth to an existing partial or complete removable denture,

— replacing an existing complete or partial denture or fixed bridgework which is at least 5 years old with a new denture or partial because it cannot be made serviceable,

— replacing a temporary denture with a permanent full denture within 12 months of when it was installed.

Covered TMJ/TMD services are paid at 50% of R&C under Prime Choice, up to a maximum lifetime benefit of $500. Before undergoing treatment for TMJ/TMD, follow the pre-treatment estimate procedures described earlier in this book.

TMJ and Other Temporomandibular Disorders (TMD) — Prime Choice Only

- Non-surgical treatment for problems specifically related to the treatment of the Temporomandibular Disorders, limited to:

  — dental splints to prevent clinching and/or grinding of teeth,

  — removable occlusal appliances,

  — biofeedback therapy, and

  — physical therapy based on Blue Cross Blue Shield's TMD Treatment Guidelines.

Orthodontics (Braces) — Prime Choice Only

- Diagnosis, installation, and related services and supplies, as necessary for treatment,

- All services related to the straightening or repositioning of the teeth, including fixed or removable orthodontic appliances and full-banded treatment, *under Prime Choice only* – for both adults and children.

Standard Choice does not cover braces. Prime Choice pays 50% of R&C up to a maximum lifetime benefit of $1,500.

The Dental Plan's payment of orthodontic services is based on the assumption that a portion of the charge is incurred at the time the appliance is installed and that the balance is billed over the period of time the appliance is expected to remain in place. For this reason, the "set-up" fee is paid immediately and the balance of benefits available are paid on a monthly basis after services have been received. Orthodontic benefits are based on the treatment plan and continue until the maximum benefit has been paid or the individual's coverage ceases, whichever occurs first. If coverage terminates after orthodontic treatment has begun but before treatment is complete, then no further benefits are available when coverage ceases, even though the orthodontic treatment may have begun prior to termination of coverage. *You should follow the pre-treatment estimate procedure as described previously before beginning orthodontic treatment.* Also, caution should be used when setting aside money in the Health Care Flexible Spending Account for out-of-pocket orthodontic expenses, so that you do not set aside too much or too little money.

Expenses Not Covered Under Either Option

You are not covered for the following dental expenses under **Prime Choice** or **Standard Choice dental**.

- Work done primarily for cosmetic purposes, except orthodontics,
- Work done while you're not covered under the dental options,
- Replacement of teeth removed or lost before coverage is effective, except:
  - — when existing partial dentures, fully removable dentures or fixed bridgework cannot be repaired and were installed before the replacement waiting period (see prosthodontics, page 12),
  - — when replacement or installation of a denture or bridgework is due to necessary additional extractions or loss of teeth while you're covered,
- Replacement of lost or stolen prosthetic devices,
- Replacement of lost or stolen orthodontic retainers,
- Extra (spare) sets of dentures or other appliances,
- Charges you're not required to pay, or charges that wouldn't normally be paid if you didn't have insurance,
- Work furnished or paid for because of service in the armed forces of any government,
- Work furnished or paid for by any government — federal, state or local,
- Services or supplies not recommended by your dentist as necessary for proper dental treatment,
- Missed appointments,
- Completion of claim forms or filing of claims,
- Educational programs, such as training in plaque control or oral hygiene, or dietary instructions,
- Charges for sealants for dependents age 14 and over,
- Implants — placing artificial teeth or supports surgically into the jawbone,
- Treatment of dental diseases or injuries resulting from declared or undeclared war, insurrection, participation in a riot, or service in the armed forces of any government,
- Work payable by any Workers' Compensation or similar laws,
- Periodontal splinting — the temporary wiring or permanent binding together of teeth, except when necessary under Prime Choice for TMJ/TMD,
- "Habit-breaking" services or appliances (for example, an appliance to aid in the prevention of thumb-sucking), unless included as a part of orthodontic treatment under Prime Choice Dental,

Treatment of Temporomandibular Joint Disorder (TMD) is not covered under Standard Choice.

- Charges for services that are considered a component of a procedure,
- Charges which, in the judgement of Blue Cross Blue Shield, exceed the reasonable and customary charge for the service or supply provided,
- Appliances, restorations and procedures to alter vertical dimension (changing the height of upper or lower teeth),
- Experimental procedures or those not recognized by the dental profession,
- General anesthesia, nitrous oxide or analgesia, except when medically necessary in connection with oral surgery or when a physical or mental condition requires its use,
- Dental services or supplies that are covered expenses under any other benefit plan or program provided by WSRC, such as dental work performed within 72 hours of accidental injury that is covered under the Health Choice medical options,
- Charges for dental services already covered under the other dental option if you switch from Standard Choice to Prime Choice or vice versa,
- Any supply item or procedure billed separately that should appropriately be built into the charge for the office visit or dental procedure (such as infection control, sterilization procedures, or supplies including latex gloves, mask and bib),
- Items billed separately for services benefiting the attending dentist or office staff rather than for the diagnosis and treatment of the patient, such as routine pre-treatment testing for HIV,
- Treatment by other than a dentist, except that scaling or cleaning of teeth and application of fluoride may be done by a licensed dental hygienist if rendered under the supervision and guidance of the dentist,
- Charges related to complications of non-covered procedures,
- Services, supplies or devices which, in the judgement of Blue Cross Blue Shield of South Carolina, are not necessary to treat a specific dental condition, (or to prevent a dental problem other than the specific Preventive Care Services described on page 11), and
- For expenses incurred after December 31, 1996, services not reported within fifteen (15) months from the date of service or within one (1) year from the end of the plan year, whichever is later.

Coordination of Benefits

If you have dental coverage under another employer's group dental plan in addition to this one — through your spouse, for example — the total benefits you are eligible to receive could be greater than your actual expenses. To help eliminate duplicate payments, your coverage under Prime Choice or Standard Choice is coordinated with payments from other group dental plans through which you have coverage. When the WSRC/BSRI dental plan is the secondary plan, it will pay up to the amount of Total Covered Charges as determined by Blue Cross Blue Shield, but the Blue Cross Blue Shield payment will not exceed the difference between the Total Covered Charges and the primary plan's payment.

Please note that "other insurance" information must be updated on an annual basis with Blue Cross Blue Shield of South Carolina.

Which Plan Pays First

If you and your spouse (through another employer) both cover your children, the plan of the parent whose birthday is first in the year will pay first.

The plan that pays first is the one that covers you as an employee. If your child is covered by more than one plan, the plan which covers the parent whose birthday falls first in the year (month and day) pays for the dependent child before the plan covering the other parent.

However, if you are separated or divorced, the plan of the parent who has custody of the child (provided that the parent hasn't remarried) will pay before the plan of the parent who doesn't have custody. If you're divorced, but have remarried and have custody of your child, your plan will pay before the child's stepparent's plan, and the stepparent's plan will pay before the plan of the children's non-custodial parent.

If a court gives financial responsibility for the child's dental care expenses to one parent, then that parent's dental plan will pay before any other plan. When none of these situations apply, the plan under which you're covered the longest will pay first.

Other plans include any dental coverage available from:

- Group, fraternal, blanket or franchise insurance,
- Prepayment coverage,
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefits organization plans, and
- Government programs, except Medicare.

Keep in mind that if both you and your spouse are employed by (or retirees of) the WSRC Team, under the "Special Rules for Dual Couples" (explained on page 3), you cannot be covered under the dental options as both an employee and as a dependent of another employee. As as result, you cannot have duplicate coverage under the WSRC/BSRI Health Choice dental options.

Each employee is covered only as an employee or as a dependent. A child is regarded as a dependent of only one employee, not both. No coordination of benefits is applicable since only one dental plan is involved.

Right of Recovery

When the Health Choice dental options pay for your (or your dependent's) dental care and you have the right to recover expenses incurred for your care from another person or organization causing your injury, Blue Cross Blue Shield of South Carolina (or its sub-contracted agent) has the right to recover the amount it paid which duplicates amounts you (or your dependent) receive through a lawsuit or a settlement with a third party or insurer. You have a legal obligation to help Blue Cross Blue Shield (or its sub-contracted agent) and WSRC recover the amount paid.

Overpayments

If Blue Cross Blue Shield issues a benefit payment, either to you or your provider, that exceeds the benefit amount you were entitled to, Blue Cross Blue Shield has the right to collect the overpayment from you or your provider. The process Blue Cross Blue Shield will follow in collecting overpayments includes:

- Send written request to be refunded, or
- Reduce the amount of the overpayment from future benefit payments.

Tips for Filing Claims

If you believe your claim wasn't paid correctly, call Blue Cross Blue Shield Customer Service at 1-800-325-6596.

Dental Services Claim Forms are available on-site via the electronic file server (OSR 5-342), from SRS Stores (Item 26-8121.00) or by calling Blue Cross Blue Shield Customer Service. Complete your portion of the claim form and take it with you when you go to your dentist. Your dentist may offer to file claims for you when you provide the necessary insurance information.

Your dentist may give you an itemized bill. Blue Cross Blue Shield can accept an itemized bill without a completed claim form as long as the following information appears clearly on the bill:

- Employee's name and Social Security number,
- Patient's name and date of birth,
- Date of service,
- Diagnosis or reason for treatment,
- Type of treatment or name of each procedure performed,
- Charge for each service, and
- In the case of an accidental injury — description of the injury and the date of occurrence.

Here are the steps to follow when filing a claim:

1– Always get a pre-treatment estimate whenever you are planning to have dental work expected to cost more than $200.

2– File claims promptly or have your dentist file your claims so you don't lose track of expenses. Remember, if you don't file a claim within the specified time limit after you incurred a dental expense (that is, within 15 months from the date of service or within one year from the end of the Plan Year, whichever is later), it will not be covered by your Health Choice Dental option. You should "cluster" the bills for each individual family member onto a separate claim form, and then put the bills in order by type of service and date. Use the correct form and/or an itemized bill. If you are coordinating benefits with another plan that is primary (such as your spouse's employer's dental insurance plan that pays first), attach a copy of the other plan's Explanation of Benefits statement to the *Dental Services Claim Form*. Keep a copy for your records — the claim form and all attachments — of the documents you send to Blue Cross Blue Shield.

3– Submit the claim form to:

Blue Cross Blue Shield of South Carolina
Claims Service Center
P.O. Box 100300
Columbia, SC 29202

4– When your claim is paid, review the Blue Cross Blue Shield Explanation of Benefits (EOB) statement to make certain you've received the correct benefits.

5– If your benefits don't appear to be paid correctly, call the Blue Cross Blue Shield Customer Service Line at 1-800-325-6596 and discuss the claim payment. Additional documentation may be required...provide it promptly.

6– If you are not satisfied with the Blue Cross Blue Shield Customer Service response or believe that the claim was incorrectly paid or denied, you should file a written appeal directly with Blue Cross Blue Shield of South Carolina. An appeal must be made within 60 days after the claim was denied. An appeal is a written letter to Blue Cross Blue Shield that provides the following:

— The claim number involved or a copy of the Explanation of Benefits (EOB) Statement,
— A copy of the Plan provision you feel was misinterpreted or inaccurately applied,
— Additional information from your dentist that will assist Blue Cross Blue Shield in completing their review of your appeal.

Blue Cross Blue Shield will review your appeal and notify you in writing of their decision, as well as the reason for the decision, with reference to specific Plan provisions.

7– If, after you have exhausted the above steps, you still believe the claim was incorrectly paid or denied, a formal ERISA (defined on page 23) appeal for a review of the denied claim should be made to:

Plan Administrator
Benefits Administration
Westinghouse Savannah River Company
Building 730-1B, Mail Stop 12
Savannah River Site
Aiken, SC 29808

Your request must be submitted within 60 days of the date your appeal was denied by Blue Cross Blue Shield. It should include all documents, records, questions or comments necessary for a complete review, including reference to the specific Plan provisions that you feel were misinterpreted or inaccurately applied.

For more information about the Plan Administrator's authority for interpreting Plan provisions and how to file a formal ERISA appeal, refer to the Claims and Appeals Section in the General Information book.

Coverage Continuation in Special Situations

If you are laid off or terminate your employment with the WSRC Team, coverage for you and your dependents will end on the last day of the pay period in which you are a full-service employee. You may be able to continue your coverage by electing COBRA continuation coverage. See information on COBRA continuation coverage below and in the General Information book.

If you die, coverage for your dependents will end on the last day of the pay period in which you die, unless they are eligible to receive survivor benefits under the provisions of the WSRC/BSRI Pension Plan and pay the required monthly premium contribution. However, to continue receiving dental benefits, survivors must also meet the definition of "Eligible Dependents" as described on page 2. Parents and step-parents are not eligible for Health Choice survivor coverage. Also, if your surviving spouse re-marries, the new spouse and his/her children cannot be added to your survivor's WSRC/BSRI dental coverage. (Note that a dependent child will no longer be covered by the WSRC/BSRI dental options upon reaching age 20, unless he/she is a full-time student at an accredited institution in which case dental coverage will continue until the child's survivor pension benefit ceases at age 21.)

If survivor benefits do not apply, your dependents will be eligible to continue their coverage by electing COBRA continuation coverage. However, if your death is a result of an occupational injury or illness while you were a full-service employee of the WSRC Team or while receiving Special Benefits for Occupational Related Disabilities under the Disability Income Plan, dental coverage may be continued for your survivors as outlined above. Your survivors will be notified of the option(s) available.

If you retire under the Normal, Voluntary, Optional or Incapability provisions of the WSRC/BSRI Pension Plan, you will be eligible to continue dental coverage for yourself and your eligible dependents. If you elect coverage for yourself (and/or your dependents if you desire to cover them), you will be required to pay the applicable after-tax monthly premium contribution. Coverage for your dependents will continue in effect as long as they continue to be eligible dependents and you elect to cover them.

If you become totally and permanently disabled, your dental coverage terminates on the last day of the pay period prior to your Total and Permanent Disability benefits beginning. You will be eligible to continue your dental coverage under COBRA continuation coverage as explained on page 21 and in the General Information book.

If you are on a paid leave of absence, your Health Choice dental coverage for yourself and your dependents will continue as if you were actively at work.

If you are on an approved Unpaid Leave of Absence (Unpaid LOA) such as a Family and Medical Leave, you will be able to continue your Health Choice dental

coverage for yourself and your dependents, if you elected to cover them, as long as you pay the required monthly premium contribution in advance. When you return from the Unpaid LOA as an active employee, your premium contributions will resume on a pre-tax deduction basis from your WSRC Team paycheck. Before your Unpaid LOA begins, be sure to contact Benefits Administration for additional information and instructions on making the required premium contributions.

If, while on an Unpaid LOA, you should fail to make your premium payments in a timely manner (that is, by no later than 31 days after the beginning of the month), your Health Choice dental coverage for you and your dependents will be terminated retroactively to the beginning of the month for which the premium contribution was not made. When you return as an active employee from the Unpaid LOA, the Health Choice dental coverage that you had just prior to the Unpaid LOA will resume, with premium contributions deducted on a pre-tax basis from your WSRC Team paycheck. However, you and your dependents would have forfeited Health Choice dental coverage during the period of time that you did not pay the required premium contributions. Dental claims incurred by you or your dependents during that uncovered period of time will not be paid by the WSRC Team.

COBRA Continuation Coverage

Under federal law — the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) — you and your eligible dependents may be entitled to continue your dental coverage for up to 18, 29, or 36 months depending on the reason for loss of coverage. Subsequent qualifying events also will determine the length of COBRA coverage. In order to be eligible for COBRA continuation coverage, you or your eligible dependents must have lost coverage under certain circumstances (such as termination of employment, divorce or death). In a divorce situation, Benefits Administration must be notified within 60 days after the effective date of the final divorce decree, or COBRA continuation coverage cannot be offered to your dependents. For more information on continuing coverage under COBRA, see the General Information book.

Disclaimer

Neither Blue Cross Blue Shield nor the WSRC Team is responsible in any way for services received from dental care providers under this plan and no guarantees are made as to the competency of the providers or the quality of services. All malpractice issues on the part of the patient or family must be directed solely at the provider of the service.

Glossary of Helpful Terms

Apicoectomy
Amputation of the root end of the tooth.

Bridgework
Artificial teeth joined to inlayed or crowned natural abutment teeth on either side. A fixed bridge for anterior teeth may require two abutments on either side. A removable bridge is currently called a partial denture.

Coinsurance
The percentage you pay for covered services. Your coinsurance amounts for non-preventive dental services are either 20%, 40% or 50%, depending on the specific dental service and the Health Choice dental option you choose.

Crown
A restoration which replaces the enamel on the visible portion of a tooth by covering the entire coronal surface, generally with porcelain, acrylic or metal.

Deductible
Under the Standard Choice Dental option, the initial amount of non-preventive dental expenses you are responsible for each year before the plan pays benefits. There is no deductible for Preventive Care services.

Endodontics
Treatment of disease or injury of the root and tissues surrounding the apex (end) of the root of the tooth.

Lifetime Maximum
The most benefits the plan will pay for an individual during his or her lifetime.

Orthodontics
The movement of teeth in the correction of malocclusion (bad bite).

Periodontics
Treatment of diseases of the gums, connective tissue and bone surrounding and supporting the teeth.

Prophylaxis
The prevention of disease through the cleaning, scaling and polishing of teeth.

Prosthetics
The installation of complete or partial dentures to replace missing “natural” teeth. Natural teeth do ***not*** include:

— Congenitally missing teeth,

— Diastema: a space between two adjacent teeth in the same arch, and

— Tooth roots when the mal-conditioned tooth existed prior to the effective date of coverage.

Reasonable and Customary
The basis for payment of covered services. The reasonable and customary charge for any given treatment is the lower of:

- The dentist's usual charge, or
- What Blue Cross Blue Shield determines to be the most common charge for a particular service in the dentist's geographic area.

Blue Cross Blue Shield takes many factors into account, such as the degree of skill needed, the complexity of the procedure, the range of services and supplies, and the prevailing charge in other areas.

Space Maintainer
An appliance to prevent adjacent teeth from moving into space left by a prematurely lost baby tooth.

ERISA Information

As a participant in WSRC's benefits program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). The official documents which govern the dental options dictate the actual operation of the Plan and the payment of benefits. For more information on your ERISA rights and administration of the Plan, refer to the General Information book.

Plan Information

Type of plan: A self-insured welfare plan that provides dental benefits

Plan Name: Health Choice Dental Plan (Prime Choice and Standard Choice)

Plan Sponsor: Westinghouse Savannah River Company and Bechtel Savannah River, Incorporated (WSRC/BSRI)

Employer Identification Numbers of The WSRC Team:
Westinghouse Savannah River Company (WSRC).....25-1575269
Bechtel Savannah River, Incorporated (BSRI).....94-3077224
Babcock and Wilcox Savannah River Company (B&W).....54-1804131
British Nuclear Fuels, Limited, Savannah River Corporation (BNFL).....54-1813446

Plan Number: 502

Plan Year: January 1 - December 31

Plan Administrator:
Benefits Administration
Westinghouse Savannah River Company
Building 730-1B, Mail Stop 12
Savannah River Site
Aiken, South Carolina 29808

Claims Administrator:
Blue Cross and Blue Shield of South Carolina
I-20 at Alpine Road
Columbia, South Carolina 29219

Agent for Legal Process:
CT Corporation System
75 Beattie Place
Greenville, SC 29601

Eligibility for benefits should not be viewed as a guarantee of employment. Also, while WSRC/BSRI intends to continue providing a comprehensive benefits program, WSRC/BSRI reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refor to the General Information book.